By: Paul H.B. No. 3348

A BILL TO BE ENTITLED

AN ACT

relating to coverage under a preferred provider benefit plan for certain services provided by out-of-network providers; authorizing a fee.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 1301, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. COVERAGE FOR CERTAIN OUT-OF-NETWORK SERVICES

Sec. 1301.251. DEFINITIONS. In this subchapter:

(1) "Database provider" means a database provider certified by the department under Section 1301.254.

(2) "Designated reimbursement information organization" means an organization designated by the commissioner under Section 1301.256.

(3) "Emergency care" has the meaning assigned by Section 1301.155.

(4) "Geozip area" means an area that includes all zip codes with the identical first three digits. For purposes of this term, the geozip area is the closest geozip area to the location in which the health care service was performed if the location does not have a zip code.

(5) "Out-of-network provider," with respect to a preferred provider benefit plan, means a physician or health care provider that is not a preferred provider of the plan.

(6) "Purchaser" means an insured under a preferred provider benefit plan, regardless of whether the insured pays any part of the insured's premium, and a sponsor of the preferred provider benefit plan, regardless of whether the sponsor pays any part of an insured's premium.

(7) "Usual and customary charge" means an average charge for a service or procedure, classified by geozip area and Current Procedural Terminology code that is in the 80th percentile of the undiscounted billed charges for that service reported to a database provider.

Sec. 1301.252. AVAILABILITY OF PREFERRED BENEFIT COVERAGE LEVELS FOR CERTAIN OUT-OF-NETWORK SERVICES. (a) An insurer shall offer coverage to the insured that provides reimbursement at the preferred level of benefits for emergency care provided by an out-of-network provider at an institutional provider that is a preferred provider.

(b) Coverage described by Subsection (a) must provide that the insured is held harmless for any amount charged by an out-of-network provider in excess of the amount of copayment, deductible, or coinsurance that the insured would have paid if the insured received the services from a preferred provider.

(c) An insurer may charge an additional premium for the coverage described by Subsection (a).

Sec. 1301.253. PAYMENT OF CERTAIN CLAIMS. (a) On receipt of a claim for payment by an out-of-network provider for a service covered under Section 1301.252, an insurer shall obtain from a database provider a certification:

(1) of the usual and customary charge for the service; or

(2) that there are not sufficient reported charges in the database provider's database to establish the usual and customary charge for the service.

(b) If an out-of-network provider submits to an insurer a claim for payment described by Subsection (a), the insurer shall pay, minus any portion of the charge that is the insured's responsibility under the preferred provider benefit plan, the lesser of:

(1) the amount that the provider would have received if the provider were a preferred provider; or

(2) the following amount provided by a database provider selected by the insurer, as applicable:

(A) the usual and customary charge for the service; or

(B) if there are not sufficient reported charges in the database provider's database to establish the usual and customary charge for the service, 80 percent of the billed charge or an amount equal to the 90th percentile of the charges for the service reported by the designated reimbursement information organization for physicians and health care providers in the same geozip area.

(c) An out-of-network provider shall accept as full payment for a claim described by Subsection (a) the total of:

(1) the portion of the charge that is the insured's responsibility under the preferred provider benefit plan; and

(2) a payment received from the insurer that complies with Subsection (b).

(d) An insurer may not pay a provider less than the amount required under this section solely because the insurer has not received a portion of the charge that is the insured's responsibility.

Sec. 1301.254. CERTIFICATION AND QUALIFICATIONS OF DATABASE PROVIDER AND DATABASE. (a) A database provider that is used to determine usual and customary charges for the purposes of this subchapter must be certified by the department. The department may certify a database provider under this subchapter only if the department determines that the database provider and the database used by the provider for the purposes of this subchapter comply with this section.

(b) A database provider must be a nonprofit organization that:

(1) maintains a database with content that complies with this section;

(2) maintains an active Internet website accessible to the public and to all insurers subscribing to the database; and

(3) demonstrates an ability to:

(A) maintain a compilation of charge data that is absent any data required to be excluded under Subsection (e)(1); and

(B) distinguish charges that are not related to one another and eliminate irrelevant or erroneous charges from reported charge information.

(c) A database provider must compute usual and customary charges for services provided by physicians or health care providers in accordance with this subchapter.

(d) The data in the database must contain out-of-network charges, classified by Current Procedural Terminology code, for physician and health care providers in each geozip area in this state.

(e) The data in the database may not:

(1) include:

(A) any data other than out-of-network billed charges from physicians and health care providers in this state;

(B) physician and health care provider charges that reflect payments discounted under governmental or nongovernmental health benefit plans; or

(C) information that is more than seven years old; or

(2) exclude charges accompanied by modifiers that indicate procedures with complications.

(f) An entity may not be certified as a database provider for the purposes of this subchapter if the entity owns or controls, or is owned or controlled by, or is an affiliate of, any entity with a pecuniary interest in the application of the database, including an insurer, a holding company of an insurer, or a trade association in the field of insurance or health benefits.

(g) The Internet website required by this section must allow an individual to determine the usual and customary charge for a particular service provided by a physician or health care provider.

(h) The department shall ensure that:

(1) the data in the database used to compute usual and customary charges of out-of-network providers is updated regularly to accurately reflect current physician and health care provider retail charges;

(2) charge information that is more than seven years old is removed from the database; and

(3) at least one entity is certified as a database provider.

(i) The department may charge a fee for certification under this section in an amount necessary to implement this section.

Sec. 1301.255. PROVISION OF USUAL AND CUSTOMARY CHARGE BY DATABASE PROVIDER. For each service for which a billed charge is submitted by a physician or health care provider to an insurer that subscribes to the database, the database provider shall provide the insurer with a certification of the usual and customary charge or a certification that there are not sufficient reported charges in the database provider's database to establish the usual and customary charge for the service, as applicable.

Sec. 1301.256. DESIGNATED REIMBURSEMENT INFORMATION ORGANIZATION. (a) The commissioner by rule shall designate an organization described by this section to report charges for services provided by physicians and health care providers for which coverage is provided under Section 1301.252.

(b) The organization designated under this section must be an independent, not-for-profit organization created to:

(1) establish and maintain a database to help insurers

determine reimbursement rates for out-of-network charges; and

(2) provide insureds with a clear, unbiased explanation of the reimbursement process.

Sec. 1301.257. DISCLOSURES REGARDING PAYMENT OF OUT-OF-NETWORK PROVIDER. (a) An insurer must provide a description of the coverage offered under Section 1301.252 on an Internet website maintained by the insurer and in a written disclosure provided to a prospective purchaser of the coverage. The description must include:

(1) the definition of "usual and customary charge" assigned by Section 1301.251 and a description of how payment to an out-of-network provider will, if applicable, be based on the lesser of:

(A) the amount the provider would have received if the provider were a preferred provider; or

(B) the following amount provided by a database provider selected by the insurer, as applicable:

(i) the usual and customary charge for the service; or

(ii) if there are not sufficient reported charges in the database provider's database to establish the usual and customary charge for the service, 80 percent of the billed charge or an amount equal to the 90th percentile of the charges for the service reported by the designated reimbursement information organization for physicians and health care providers in the same geozip area;

(2) examples of the anticipated portion of the charge

that will be the insured's responsibility for specific services for which out-of-network providers frequently bill in situations for which coverage is offered under Section 1301.252;

(3) a methodology for determining the anticipated portion of the charge that will be the insured's responsibility for a specific service that is based on the amount, not an approximation, that the insurer pays;

(4) the Internet website addresses of each database provider certified under this subchapter at which a purchaser or prospective purchaser may access the database or a single website address at which an updated set of links to the website addresses of those database providers may be accessed; and

(5) a statement that if the insurer's payment due under coverage provided under Section 1301.252 is not sufficient to cover the total billed charge, the physician or health care provider agrees to accept as payment in full the amount paid by the plan in accordance with the coverage provisions plus any portion of the charge that is the insured's responsibility under the plan.

(b) Disclosures under this section must:

(1) be made in language easily understood by purchasers and prospective purchasers of preferred provider benefit plans;

(2) be made in a uniform, clearly organized manner;

(3) be of sufficient detail and comprehensiveness as to provide for full and fair disclosure; and

(4) be updated as necessary to ensure that the disclosures are accurate.

SECTION 2. Subchapter F, Chapter 1301, Insurance Code, as added by this Act, applies only to a preferred provider benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2018. A plan delivered, issued for delivery, or renewed before January 1, 2018, is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.

SECTION 3. This Act takes effect September 1, 2017.